STATE OF MICHIGAN

IN THE SUPREME COURT

COVENANT MEDICAL CENTER,

Plaintiff-Appellee,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, a Michigan insurance corporation,

Defendant-Appellant.
_____/

Supreme Court No. 152758

Court of Appeals No. 322108

Saginaw County Circuit Court No. 13-020416-NF

AMICUS CURIAE BRIEF OF THE INSURANCE INSTITUTE OF MICHIGAN

PROOF OF SERVICE

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STATEMENT OF THE QUESTIONS PRESENTED

1. Does a healthcare provider of a motor vehicle accident victim possess a right to enforce an insurer's obligation to pay no-fault benefits?

   Amicus Curiae, Insurance Institute of Michigan, answers, "No."

2. Even if healthcare providers are determined to possess a right to claim payment of no-fault benefits owed by an insurer, would any such claim remain dependent on the insurer being obligated to pay benefits on behalf of the insured, and thus would a release of claims or other resolution of the insured's rights against the insurer bar the provider's claim?

   Amicus Curiae, Insurance Institute of Michigan, answers, "Yes."

INTEREST OF AMICUS CURIAE

On behalf of its member companies, the Insurance Institute of Michigan ("IIM") is interested in the very significant issues raised in the case at bar. At issue, specifically, is whether Michigan no-fault insurers and the injured persons they insure will remain able to negotiate and resolve contested claims for benefits efficiently and with a minimum of litigation. It is beyond dispute that their ability to do so is essential to the no-fault act's basic goals of relieving the overburdened court system and remedying the long delays in payment that were so commonplace in the tort system it replaced. *McCormick v Carrier*, 487 Mich 180, 189; 795 NW2d 517 (2010), quoting, *Shavers v Attorney General*, 402 Mich 554, 579; 267 NW2d 72 (1978); see also, *US Fidelity & Guaranty Ins Co v MCCA*, 484 Mich 1, 25; 795 NW2d 101 (2009).

The decision of the Court of Appeals in this case is inimical to these goals. If left unaltered, the procedures established by the Court's published opinion virtually eliminate the ability of parties to settle even the simplest of no-fault claims without judicial intervention. Moreover, the Court of Appeals' holding, along with the procedures it requires, ultimately rests on the basic premise that healthcare providers possess a right to "claim" benefits from an accident victim's no-fault insurer. The IIM maintains that this premise is insupportable, yet it has persisted with the support of a line of Court of Appeals opinions and has greatly multiplied no-fault insurance litigation.

The IIM represents over 80 property/casualty insurance companies and related organizations operating in Michigan. Its member companies provide insurance to approximately 75% of the automobile market in Michigan and are interested in the ongoing

development of automobile no-fault and liability insurance in Michigan. The case now pending before the Court raises issues that are of great importance to both the insurance industry and Michigan's purchasers of mandatory automobile insurance, and accordingly, to Amicus Curiae IIM.

INTRODUCTION

When the Court of Appeals issued its published opinion in *Covenant Medical Center, Inc v State Farm Auto Ins Co*, 313 Mich App 50; 880 NW2d 294 (October 22, 2015) (Joint Appendix, 80a), it sent shockwaves through the no-fault insurance world. On that date, four decades of established no-fault claim handling and litigation practice, under which claims for personal protection insurance benefits routinely were negotiated and resolved directly with the injured person entitled to the benefits, was fundamentally dismantled.

Construing and relying upon MCL 500.3112 of the no-fault act as it had never been construed and applied before, the Court of Appeals held that an insurer's "payment" of settlement monies to an injured person, pursuant to a negotiated resolution and binding agreement for "release" of the injured person's claims, leaves the insurer exposed, post-settlement, to litigation filed directly by the injured person's healthcare providers. According to the Court of Appeals' opinion, this post-settlement exposure exists if, at the time of settlement, the insurer was in possession of a provider's bill for services rendered yet failed to notify the provider of the intended "payment" and obtain a circuit court order apportioning distribution of the settlement proceeds. *Covenant Medical*, 313 Mich App at 53. As a consequence of the procedures required by the appellate court's new construction of §3112,

under which circuit court "apportionment hearings" now precede virtually any final settlement, resolution of even the most common no-fault insurance disputes efficiently and with a minimum of litigation has become an impossibility.

What is more, the analysis on which the Court of Appeals based these new procedural requirements is demonstrably flawed. It fundamentally misreads MCL 500.3112 and, as a consequence, not only applies §3112 to circumstances that in fact are not governed by the provision, but also confers a brand new right of immunity on healthcare providers–a right to avoid the consequences of the bars of "release" and *res judicata*–thereby expanding on the already tenuous "right" previously conferred by the Court of Appeals allowing healthcare providers to bring direct claims against their patient's no-fault insurers in the first place.

Thus it is the healthcare provider's purported "right" to enforce an insurer's obligations under the no-fault act that constitutes the essential premise on which the Court of Appeals' holding ultimately is based; and it is this fiction of a provider's right of action that in recent years has blossomed to an explosion of litigation against no-fault insurers, often involving multiple actions arising out of a single person's injuries.

Accordingly, this brief will show, first and foremost, that this premise on which the Court of Appeals' holding is based is insupportable. Hospitals, physicians, and other healthcare and service providers do not, after all, have any viable legal basis for suing no-fault insurers to enforce an injured person's entitlement to benefits. Quite simply, while personal protection insurance benefits are payable to (or for the benefit of) an injured person, they are *not* payable to (or for the benefit of) an injured person's provider of services. That a check may be issued directly to a healthcare provider *for the benefit of the injured person* does not

equate to a healthcare provider being entitled to claim no-fault benefits. No such entitlement belongs to the healthcare provider; it belongs exclusively to the injured person (or, in the case of death, to his surviving dependents).

And second, in the event one were to accept the premise that providers have a right to sue an insurer for payment of the insured's service bills, this brief will show that any such right is inherently derivative of and dependent upon the insured having a valid claim for benefits; and contrary to the Court of Appeals' holding, no immunity from the barring effect of release or *res judicata* is conferred on providers by §3112.

For the following reasons, Amicus Curiae IIM submits that the Court should reverse the Court of Appeals in this case and hold that the no-fault act confers no right of any kind on healthcare providers.

ARGUMENT

I. THE *COVENANT MEDICAL* HOLDING IS FATALLY DEPENDENT ON THE INSUPPORTABLE PREMISE THAT HEALTHCARE PROVIDERS POSSESS THE RIGHT TO ENFORCE AN INSURER'S OBLIGATIONS UNDER THE NO-FAULT ACT.

In its brief opinion, the Court of Appeals in this case quotes most of §3112 of the no-fault act, MCL 500.3112, purporting to apply "'the plain and ordinary meaning of the language of the statute[.]'" *Covenant Medical*, 313 Mich App at 52, quoting *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins*, 250 Mich App 35, 37; 645 NW2d 59 (2002). The portion of the statute emphasized by the Court is its second sentence:

> ". . . *Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's*

> *liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.*"

Covenant Medical, at 53 (emphasis in original). By its terms, the statute then proceeds to permit an insurer, or any other interested person, to apply to the circuit court for an order equitably apportioning the payment of benefits "if there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto[.]" §3112 (third sentence).

Based on these provisions, the Court of Appeals concluded that an insurer must seek circuit court intervention, with notice to any healthcare provider whose written notice of "claim" has been received by the insurer, to obtain an order apportioning "payment" of the agreed-upon settlement between the insurer and the injured person. Failure to do so, the Court held, leaves the insurer liable for the "claim" of any such healthcare provider that was not included in the apportionment hearing process. *Covenant Medical*, at 53:

> [T]he plain text of the statute provides that if the insurer has notice in writing of a third party's *claim*, then the insurer cannot discharge its *liability to the third party* simply by settling with its insured. Such a payment is not in good faith because the insurer is aware of a *third party's right* and seeks to extinguish it without providing notice to the affected third party. Instead, the statute requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated. That was not done in this case. Accordingly, pursuant to the plain language of the statute, because State Farm had notice in writing of Covenant Medical's *claim*, State Farm's payment to Stockford [the injured person] did not discharge its *liability to* Covenant Medical.

Id. (emphasis added).

As the italicized words in the above quotation plainly reveal, the Court of Appeals' holding–along with the myriad new time and expense consuming procedures it mandates, is

founded on the premise that a healthcare provider such as Covenant Medical Center possesses a third party "right" to recover benefits from the injured person's no-fault insurer; that it does, in fact, have a viable "claim" to enforce an insurer's "liability to the third party" healthcare provider.

This fundamental premise is invalid. The authorities cited by the Court of Appeals for the proposition that healthcare providers possess such a right demonstrably fail to support the premise. As a matter of contract law, healthcare providers are neither parties to, nor intended third-party beneficiaries of, the no-fault insurance policies on which they would base their "claims"; and while §3112 irrefutably does regard non-contracting "injured persons" and "dependents" of fatally injured persons as intended third-party beneficiaries of any no-fault insurance policy, it manifestly does *not* so regard healthcare providers or others who might incidentally benefit from an injured person's insurance coverage.

There is, therefore, no contractual basis for service providers to pursue recovery of benefits from no-fault insurers; and neither §3112 nor any other provision in the no-fault act creates a statutory cause of action allowing them to do so. Absent either a statutory or common law ground on which to base a claim, a healthcare provider simply has no legally viable "claim" enforceable against the no-fault insurer.

A. Case law cited for the proposition that healthcare providers have a viable "claim" to assert against no-fault insurers is not based on any positive or primary law and thus ultimately fails to support the premise.

The holding in *Covenant Medical* is dependent on the proposition that one who provides healthcare services to a motor vehicle accident victim possesses a "claim" against the person's

no-fault automobile insurer to compel payment of benefits on behalf of the insured. As in prior cases, the Court of Appeals proceeded on the assumed premise, based loosely on MCL 500.3112 but more so on passing statements and assumptions made in earlier Court of Appeals opinions, that providers do possess direct claims of their own against no-fault insurers.

Case law precedent, however, is not itself authority for the proposition that a right of action exists, but is authoritative only to the extent that it identifies and relies upon some primary law, be it a statute or the common law. In this case, State Farm maintained that the injured party's release of all claims necessarily precluded Covenant Medical Center from suing State Farm. In response, with a citations of authority, the Court of Appeals stated as follows:

> [I]t is also well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits. *Wyoming Chiropractic Health, PC v Auto- Owners Ins Co*, 308 Mich App 389, 396-397; 864 NW2d 598 (2014); *Moody*, 304 Mich App at 440; *Mich Head & Spine*, 299 Mich App at 448 n 1; *Lakeland Neurocare Ctrs*, 250 Mich App at 42-43; *Regents of Univ of Michigan v State Farm Mut Auto Ins Co*, 250 Mich App 719, 733; 650 NW2d 129 (2002).

Covenant Medical, 313 Mich App at 54. It turns out, upon closer examination, that this "well settled" premise is utterly unsupported.

The opinion first cited, *Wyoming Chiropractic Health, PC v Auto-Owners Ins Co*, 308 Mich App 389; 864 NW2d 598 (2014), *lv den*, 497 Mich 1029 (2015), does not itself analyze §3112 (or any other section of the no-fault act) as establishing a cause of action for providers, but instead relies on prior cases as already having established the premise as "fact":

> Recently, this Court *reiterated* the *fact* that the no-fault act creates an independent cause of action for healthcare providers when it stated, "We note that the language 'or on behalf of' in the release is similar to the phrase 'or for the benefit of' in

> MCL 500.3112, which this Court *has recognized* creates an independent cause of action for healthcare providers."

Wyoming Chiropractic, 308 Mich App at 396 (emphasis added). For this proposition, the two cases quoted and cited by the Court (*Wyoming Chiropractic*, at 396 n 42) are *Mich Head & Spine v State Farm Mut Auto Ins Co*, 299 Mich App 442; 830 NW2d 781 (2013), and *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*, 250 Mich App 35; 645 NW2d 59 (2002).

In *Michigan Head & Spine*, however, the Court likewise did not analyze the statutory issue. Rather, it merely referenced the phrase "for the benefit of" in §3112 and added, "which this Court has recognized creates an independent cause of action for health care providers." 299 Mich App at 448 n 1, citing only *Lakeland Neurocare*.

Yet the opinion in *Lakeland Neurocare* itself, which both *Wyoming Chiropractic* and *Michigan Head & Spine* cite for the proposition that the Court of Appeals ever held that the act creates a cause of action for health care providers, *did not even address the issue*. The parties in that case "*did not dispute* that plaintiff [the provider] had the legal right to commence this action for payment of medical services rendered to defendant's insured." 250 Mich App at 37 (emphasis added). The Court assumed that the provider did have a right to sue the insurer directly. Based on that assumption, the issue presented was whether the provider *also* could recover penalty interest and attorney fees under MCL 500.3142 and MCL 500.3148(1),[1] and the Court held that it could. The Court in *Wyoming Chiropractic* then turned this point entirely upside down by concluding, in essence, that since a healthcare provider *can* collect penalty

[1] "The issue, however, is whether plaintiff had the right to attempt enforcement of the penalty interest and attorney fee provisions of the no-fault act[.]" *Lakeland Neurocare*, 250 Mich App at 37-38.

interest from a no-fault insurer, it certainly must have the right to bring a cause of action to recover the underlying PIP benefits themselves. *Wyoming Chiropractic*, 308 Mich App at 397-398, relying on *Lakeland Neurocare*, *supra*.

Regents of Univ of Michigan v State Farm Mut Auto Ins Co, 250 Mich App 719; 650 NW2d 129 (2002), is also cited by the Court of Appeals as establishing the premise that a healthcare provider can assert a claim against an insured's no-fault insurer, yet that opinion does not even cite MCL 500.3112, let alone decide whether it provides a basis for a provider to sue the insurer. The only issue addressed was whether the plaintiff, a Michigan public hospital and thus a political subdivision of the state, was subject to the no-fault act's 1-year back rule of MCL 500.3145(1) in light of the protection from statutes of limitations given by MCL 600.5821(4). *Id.*, 250 Mich App at 732-733.

Nor, finally, does *Moody v Home Owners Ins Co*[2] support the Court of Appeals' assertion that a provider's right to sue a no-fault insurer for benefits "is well established." The Court in *Moody* merely assumed, without citation, that such a cause of action does exist; the central point of the Court's opinion was that any such right of action is not so "independent" after all:

> While the providers may bring an independent cause of action against a no-fault insurer, the providers' claims against Home Owners are completely derivative of and dependent on Moody's having a valid claim of no-fault benefits against Home Owners.

Moody, 304 Mich App at 440.

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[2] 304 Mich App 415; 849 NW2d 31 (2014), *lv gt'd*, 497 Mich 866 (2014), *app dis'd*, __ Mich __; 858 NW2d 462 (February 4, 2015).

The essential premise on which the challenged decision in this case stands–that a medical provider has an independent right to bring a claim against an insurer for the payment of no-fault benefits (313 Mich App at 54)–thus is not nearly as "well settled" as the Court suggests. It is supported by nothing but precedential quicksand. Upon fresh examination as to whether there is, in fact, any statutory or common law basis for recognizing such a right, the Court will find that there is none.

B. Neither the common law of contracts nor any provision in the no-fault act confers on healthcare providers a right to claim benefits from a no-fault insurer.

If Covenant Medical and its amici curiae are to demonstrate that healthcare providers possess a right of action to recover benefits from a no-fault insurer, they must be able to identify the source of the right in some form of positive law. This they cannot do. The common law of contracts, and specifically third-party beneficiary law, does not confer on healthcare providers a right of action, notwithstanding the "for the benefit of" phrase in the first sentence of §3112. The following will show that their repeated but vague reliance on this phrase is fundamentally misplaced. Nor can the healthcare providers identify in the no-fault act any purely statutory source as creating their purported right to sue an insurer for benefits. And absent either a common law or statutory basis for their claimed right of action, it must be concluded that the providers simply have no such claim at all.

1. Healthcare providers have no contractual basis to enforce a no-fault insurer's obligation to pay benefits because they are not intended third party beneficiaries of the insurance policy contract, and nothing in §3112 dictates otherwise.

Never is a healthcare provider one of the contracting parties to the insurance contract between the no-fault insurer and the injured person receiving the provider's services.

Accordingly, a provider would be entitled to sue the insurer on the contract only if it could establish that it has rights as a third-party beneficiary to the insurance contract. Yet healthcare providers manifestly do not have third-party beneficiary status under the no-fault act. Therefore, *absent an express assignment of rights*[3] from one who does have enforceable rights under the insurance contract, there simply is no legal basis for a provider to assert an enforceable claim against the no-fault insurer.

The purpose of the no-fault insurance system is to protect *injured persons*, or, in the case of a fatally injured person, his or her *dependents*. This has been clear since the inception of the act. *Coburn v Fox*, 425 Mich 300, 309; 389 NW2d 424 (1986); *Shavers v Attorney General*, 402 Mich 554, 596; 267 NW2d 72 (1978). Nothing in the no-fault act, either within the text of §3112 or otherwise, states that personal protection insurance ("PIP") benefits are payable to or for the benefit *of medical care providers*. Benefits can be paid to the injured person, and they also can be paid to a medical care provider or other third person *if such payment benefits the injured person*, but a payment is never made for the purpose of benefitting the medical care provider or other third person.

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[3] "[A]n assignee of a cause of action becomes the real party in interest with respect to that cause of action, inasmuch as the assignment vests in the assignee all rights previously held by the assignor." *Cannon Twp v Rockford Pub Schools*, 311 Mich App 403, 412; 875 NW2d 242 (2015), citing *Kearns v Michigan Iron & Coke Co*, 340 Mich 577, 582-584; 66 NW2d 230 (1954). An assignment of the right to payment confers on the assignee *derivative* standing to sue, in the sense that the assignee's rights derive entirely from the assignor; it acquires no greater and no fewer rights than the assignor had to give. *Brown v BlueCross BlueShield of Tenn*, 827 F3d 543, 547-548 (CA 6, 2016).

Notably, while MCL 500.3143 declares an assignment of *future* PIP benefits void, it does not prohibit an assignment of the right to claim PIP benefits already due based on expenses already incurred. *Professional Rehabilitation Assoc v State Farm Mut Auto Ins Co*, 228 Mich App 167, 172; 577 NW2d 909 (1998).

For ease of reference, §3112 of the no-fault act, in its entirety, states as follows:

> **Personal protection insurance benefits are payable *to or for the benefit of an injured person* or, in case of his death, *to or for the benefit of his dependents***. Payment by an insurer in good faith of personal protection insurance benefits, *to or for the benefit of* a person who it believes is entitled to the benefits, discharges the insurer's to the extent of the payments unless the insurer has been notified in writing of *the claim of some other person*. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
>
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
>
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

MCL 500.3112 (emphasis added).

The critical flaw in *Covenant Medical*, IIM submits, is the Court of Appeals' conclusion that a healthcare provider's submission of a bill, even one accompanied by a request for payment, constitutes an enforceable "claim" for PIP benefits, thereby creating "doubt about the proper person to receive the benefits or the proper apportionment among persons entitled thereto," and consequently rendering the insurer's payment of PIP benefits to the injured person not "in good faith." *Covenant Medical*, 313 Mich App at 53. This is incorrect.

As discussed above, the Court of Appeals relied on several prior opinions for the "well-settled" rule that providers have an independent right to bring claims against no-fault insurers.

Id., at 54. These earlier opinions, in turn, to the extent they explore a legal basis for the stated proposition at all, point generally to the "*or for the benefit of* an injured person" language in the first sentence of §3112. By implication, the Court of Appeals has regarded the phrase as revealing a legislative intent to make healthcare providers intended third-party beneficiaries of the no-fault policies issued by insurers, thus granting the providers a right to sue and enforce the policies. But this manifestly is not so.

In MCL 600.1405, the Legislature explicitly defined the limited class of persons able to seek judicial enforcement of another's contract. In pertinent part, the statute states as follows:

> Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.
>
> (1) A promise shall be construed to have been made *for the benefit of* a person whenever the promisor of said promise has undertaken to give or to do or refrain from doing *something directly* ***to or for said person***.

MCL 600.1405 (emphasis added). In this provision, the Revised Judicature Act addresses who can and who cannot sue in connection with a contract. Application of this limiting language to actions brought under the no-fault act reveals that, while there are indeed certain non-contracting parties who have the status of a third-party beneficiary to enforce a no-fault insurer's obligations under its policy contract, healthcare providers are not among them.

In *Schmalfeldt v North Pointe Ins Co*, 469 Mich 422, 429; 670 NW2d 651 (2003), the Court confirmed that the Legislature's use of the "directly to or for" language in §1405(1) unambiguously signals that "[o]nly intended beneficiaries, not incidental beneficiaries, may

enforce a contract under §1405." This conclusion is supported by the interpretive tenet of *expressio unius est exclusion alterius*, meaning that the Legislature's express mention of one thing in a statute necessarily means that it intended to exclude other similar things. *Bradley v Saranac Community School Bd of Ed*, 455 Mich 285, 298; 565 NW2d 650 (1997). Here, the Legislature thus necessarily intended that mere incidental third-party beneficiaries *do not* have a right to seek judicial enforcement of a contract, such as an insurance policy, since otherwise there would have been no need for the Legislature to state that intended third-party beneficiaries do have such rights.

Contrary to the assertions of Plaintiff-Appellee and its amici curiae,[4] the fact that MCL 500.3112 makes benefits payable to "or for the benefit of" an injured person does *not* confer third-party beneficiary status on an injured person's healthcare provider. Nothing in §3112 mandates that a no-fault insurer *ever* pay benefits directly to "*or for*" the benefit of an injured person's healthcare provider. *Id.*; MCL 600.1405(1). The Legislature's placement of the "to or for the benefit of" language in §3112, therefore, could not have been to make healthcare providers third-party beneficiaries of no-fault insurance policies. See *Schmalfeldt*, 469 Mich at 428.[5]

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[4] Appellee Covenant Medical Center's Brief on Appeal, 9/15/16, pp. 11-14; Amicus Curiae Brief of Michigan Health and Hospital Association, 10/6/16, p. 23, at n. 6; Amicus Curiae Brief o the Coalition Protecting Auto No-Fault, 10/6/16, pp. 6-9.

[5] "A person is a third-party beneficiary of a contract only when that contract establishes that a promisor has undertaken a promise 'directly' to or for that person. ... By using the modifier 'directly,' the Legislature intended 'to assure that contracting parties are clearly aware that the scope of their contractual undertakings encompasses a third party, directly referred to in the contract, before the third party is able to enforce the contract.'" *Schmalfeldt*, 469 Mich at 428, quoting *Koenig v South Haven*, 460 Mich 667, 677; 597 NW2d 99 (1999), and MCL 600.1405(1).

Rather, reading §3112 in conjunction with MCL 600.1405(1) makes clear that the Legislature's intent in using the phrase "to or for the benefit of" in the first sentence of §3112[6] was to mandate that *non-policyholder* ***injured persons*** and, in the case of fatal injuries, ***dependents*** of injured persons, be third-party beneficiaries under no-fault insurance policies and therefore possess a right to enforce the policy contract directly against the insurer. A healthcare provider is not an injured person, nor is it a surviving dependent of a fatally injured person. The statute confers third-party beneficiary status only on these two categories of persons.

Indeed, precisely because there was no such legislative boost in *Schmalfeldt v North Pointe Ins Co*, *supra*, the injured person in that case was unable to enforce the "medical payments provision" of the insurance contract between the defendant insurer and its commercial policyholder, the Elite Bar. The policy provided for up to $5,000 in medical expenses payments without regard to fault for injuries occurring on the insured's premises, but the payment of benefits was not promised "directly to or for" the benefit of the injured patron. Accordingly, while the contracting policyholder itself had the right to enforce the insurer's obligations under the policy (it chose not to), the injured plaintiff himself had no such right:

> Nothing in the insurance policy specifically designates Schmalfeldt, or the class of business patrons of the insured of which he was one, as an intended third-party beneficiary of the medical benefits provision. ...
>
> ... This agreement is between the contracting parties, and Schmalfeldt is only an incidental beneficiary without a right to

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[6] "[PIP] benefits are payable *to or for the benefit of* ***an injured person*** *or*, in case of his death, *to or for the benefit of* ***his dependents***." §3112 (emphasis added).

> sue for contract benefits. For this reason, North Pointe is entitled to summary disposition.

Schmalfeldt, 469 Mich at 429.

Similar to the med-pay coverage provided by the policy in *Schmalfeldt*, no-fault insurance policies likewise provide for payment of an injured person's medical expenses without regard to fault. Under the no-fault act, however, third-party beneficiary status *is* conferred upon injured persons and their dependents, which allows them, unlike the plaintiff in *Schmalfeldt*, to pursue recovery of benefits directly from the insurer. To be sure, any person–not just a healthcare provider–who provides and charges for necessary services to an injured person derives an incidental benefit from the existence of insurance coverage applicable to the expense of their services; but while the act confers third-party beneficiary rights on injured persons, no such rights are conferred upon service providers.

This analysis is fully supported by extensive case law from other no-fault insurance states. For instance, applying Kentucky's no-fault insurance law in *United States v Allstate Ins Co*, 754 F2d 682 (CA 6, 1985), the federal appellate court held that the plaintiff, having provided medical services to an army serviceman injured in an automobile accident but having not received an assignment of the injured person's rights, could not sue the no-fault insurer for payment. *That the statute made healthcare providers optional payees* (as does §3112) *did not alter this conclusion*:

> [I]n providing that "medical expense benefits may be paid by the [insurer] directly to persons supplying products, services, or accommodations to the claimant," [the statute] makes the provider an optional payee or incidental beneficiary of no-fault policies in order to facilitate the insured person's receipt of

> benefits, and does not make the provider a third party beneficiary with a right to enforce the insurance contract.

United States v Allstate Ins Co, 754 F2d at 666.

Later, in *Neurodiagnostics, Inc v Ky Farm Bureau Mut Ins Co*, 250 SW3d 321 (Ky, 2008), the Kentucky Supreme Court reached the same conclusion even after the Kentucky statute had been amended to disallow assignments to healthcare providers:

> Reading [the new provision] in light of the [Motor Vehicle Reparations Act] as a whole, we conclude that a medical provider, such as LDC, is an optional payee or incidental beneficiary of the no-fault policies.[ ] And, as an incidental beneficiary, LDC has no direct right of action against the reparation obligor [insurer]. If a medical provider does not receive payment from the reparation obligor, either because benefits have been exhausted (the State Farm case) or because the reparation obligor determines that the charges were neither reasonable nor medically necessary (the Farm Bureau case), then the insured is the party that is ultimately responsible for payment. And it is the insured that has the direct right of action against the reparation obligor if he or she disagrees with the way in which his or her benefits were either paid or not paid.
>
> We conclude that a medical provider has no standing under the MRVA to bring a direct action against the reparation obligor/insurer.

Neurodiagnostics, Inc v Ky Farm Bureau Mut Ins Co, 250 SW3d at 329 (footnoted citation omitted).

The same approach is followed in Pennsylvania under its No-Fault Motor Vehicle Insurance Act, which, like Michigan's act, does not disallow assignment of rights to benefits already accrued. In *Ludmer v Erie Ins Exchange*, 295 Pa Super 404; 441 A2d 1295 (1982), the issue presented on appeal was "whether a doctor who has allegedly rendered medical services to an insured victim of a motor vehicle accident has the right to sue an insurance

company directly as a third party beneficiary of the contract between the company and its insured." 441 A2d at 1295-1296. The court said no, concluding that neither the governing no-fault statute nor the insurance contract supported such a right (*id*.). The opinion concludes with the following apt observations:

> The scheme of the No-Fault Act itself, and the contract between the parties in the instant action, certainly do not preclude direct payment to a service provider by an insurance company. Ordinarily, such a course is efficient and sensible. It is not mandated, however, and the ordinary and prudent scheme of the law of contracts is not abrogated by the No-Fault Act. *We cannot find that a service provider becomes a third party beneficiary of the contract in the instant action, and thus the real party in interest, merely upon the allegation that he has rendered services to the insured and presented a bill for those services to the insurer*.
>
> As the lower court states, the service provider is not seriously hampered in his ability to recover monies genuinely owed him. Where the parties amicably agree to assignment of the claim, as is usual, payment will be direct and prompt. Where problems develop, the service provider may obtain judgment against the insured and institute garnishment proceedings against the insurer.

Ludmer v Erie Ins Exchange, 441 A2d at 1296 (emphasis added).

Accord, *Parrish Chiropractic Ctrs, PC v Progressive Cas Ins Co*, 874 P2d 1049, 1056-1057 (Colo, 1994) ("Parrish can cite no intent on the part of the legislature to create a third-party beneficiary relationship under these facts. Accordingly, we agree with both the trial court and the court of appeals that Parrish is only an incidental beneficiary of the Progressive PIP policy and, as such, is not entitled to recovery in a direct action to enforce the terms of the policy."); *Elsner v Farmers Ins Group*, 220 SW3d 633 (Ark, 2005) (addressing issue of first impression, where no-fault auto insurer denied payment of provider's charges on grounds of

reasonableness and necessity, plaintiff chiropractor was merely an incidental beneficiary and thus lacked a basis to bring a direct action against the insurer). The same conclusions have been reached in the analogous and parallel settings of worker's compensation coverage[7] and group health insurance policies.[8]

There simply is no contractual basis, therefore, for healthcare providers in Michigan to claim entitlement to payment of benefits from an injured person's no-fault insurer. They are neither parties to, nor intended third-party beneficiaries of, the no-fault insurance policies on which they would base their claims. While the no-fault act clearly does confer third-party beneficiary status on "injured persons" and "dependents" of fatally injured persons,[9] it manifestly does *not* do so with respect to healthcare providers. The underlying assumptions to the contrary, which ultimately inform the prior Court of Appeals' opinions on which the fiction of the provider's claim rests, should be exposed by this Court and rejected.

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[7] *Martis v Grinnell Mut Reinsurance Co*, 905 NE2d 920, 927 (Ill App, 2009) (as chiropractor was not a "person entitled to benefits" under statute and was not a third-party beneficiary of the policy, he had no right to enforce it); *Jou v Nat'l Interstate Ins Co of Haw*, 157 P3d 561, 572 (Haw, 2007) (holding medical provider was merely an incidental beneficiary of the employer's worker's compensation insurance policy, where the statutory scheme was designed "to compensate employees for work-related injuries, not to compensate physicians"); *Furno v Citizens Ins Co*, 590 NE2d 1137, 1141 (Ind App, 1992) (rejecting proposition that physician treating injured employee was a third-party beneficiary of worker's compensation policy).

[8] *Kelly Health Care, Inc v Prudential Ins Co*, 309 SE2d 305, 307 (Va, 1983); *Zweig v Metropolitan Life Ins Co*, 73 Misc 2d 93; 340 NYS2d 817 (1972).

[9] Thus, again under the *expressio unius est exclusion alterius* maxim, by identifying a particular class of persons (injured persons and dependents) as intended third-party beneficiaries able to claim benefits under a policy contract to which they are not a party, the Legislature manifestly intended that other persons, such as providers of services, are *not* to be regarded as third-party beneficiaries able to assert claims against the policy.

2. The no-fault act does not otherwise confer on healthcare providers a statutory right of action against no-fault insurers for recovery of an injured person's no-fault benefits.

If a healthcare provider has no contractual basis for asserting a direct claim for benefits against a no-fault insurer, then either the provider must have a *statutory* cause of action or else it has no rights against the insurer at all. The preceding discussion shows there is no such contractual basis; the following shows that there likewise is nothing in the act conferring on providers any statutory entitlement to recover from insurers.

The section of the no-fault act that creates a no-fault insurer's liability for payment of PIP benefits is MCL 500.3105(1); but it does not identify to whom the insurer is liable:

> Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter.

Id. Similarly, MCL 500.3107 and MCL 500.3108 describe in detail the economic losses for which benefits "are payable" under personal protection insurance (the latter addressing survivors' loss in the event of the injured person's death), but again the provisions do not identify to whom, or for whom, the benefits are payable. They do not identify those who have a right to "claim" benefits.

In contrast, several sections of the act do reveal an intent to permit an injured person (whether party to the insurance contract or not) to claim benefits from a no-fault insurer. Both §3114(2) and §3114(3) speak of persons "suffering accidental bodily injury" being "entitled" to recover benefits from the responsible insurer. MCL 500.3114(2) (the injured operator or

passenger "shall receive [benefits] from the insurer of the motor vehicle"); MCL 500.3114(3) (the injured employee "shall receive [PIP] benefits ... from the insurer of the furnished vehicle").

Likewise, §§ 3114(4), (5), and 3115(1) all identify the "person suffering accidental bodily injury" as the one who "shall claim [PIP] benefits from" specified insurers by order of priority. These sections of the act, the Court has held, "constitute both entitlement provisions and priority provisions." *Belcher v Aetna Cas & Sur Co*, 409 Mich 231, 251-252; 293 NW2d 594 (1980). Nowhere in these "entitlement" provisions, however, is there any arguable reference to a healthcare provider being "entitled" to benefits under the act or being directed to "claim" benefits from any insurer.

Indeed, as the Court emphasized in *Belcher*, not even surviving dependents are given "an express entitlement to claim benefits" from a no-fault insurer. 409 Mich at 255. Yet since §3108 creates benefits specifically *for* surviving dependents, "*and benefits are made payable to surviving dependents under §3112*," the Court concluded that they, too, possess a right of action against the insurer. 409 Mich at 254-255 (emphasis added). Thus, the Court held:

> [I]t is necessary to infer from the language of §3114 and §3115 that where an injured person is given the right to recover benefits from a specific insurer, his surviving dependents have the same right of recovery for their losses.[27] In this way, a survivor's entitlement to benefits may be said to be derivative of or dependent upon the deceased injured person's entitlement to benefits had he survived.

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[27] Thus, phrases used throughout §3114 and §3115 such as "a person suffering accidental bodily injury" "shall claim" or "shall receive" should be construed to mean "a person suffering accidental bodily injury *or his or her survivors*" "shall claim" or "shall receive" personal protection insurance benefits. This construction is further

> supported in that the definition of bodily injury includes death. MCL 500.3105(3).

Belcher, 409 Mich at 255 (emphasis in original).

The analysis in *Belcher* instructs that while the literal text of the act gives *only* injured persons the right to assert a claim for benefits against the no-fault insurer, this right of action is necessarily construed to include an injured person's surviving dependents based principally on §3112, which expressly makes PIP benefits payable "to or for the benefit of [an injured person's] dependents." In this way, surviving dependents are held to possess a right to claim benefits from the insurer, even though that right is derivative of and dependent upon the injured person's rights. *Belcher*, *supra*. No similar statutory basis exists for recognizing such a claim on the part of an injured person's service providers.

There are isolated instances in the no-fault act where an affirmative right of recovery is conferred on one who is neither an injured person nor a surviving dependent of a fatally injured person; but in each such instance that right of recovery is provided only to a no-fault insurer. See, MCL 500.3114(6) and MCL 500.3115(2) (both declaring an insurer "entitled to partial recoupment" from other insurers where they share the same order of priority with respect to an injured person's benefits); MCL 500.3177 (declaring that an insurer obligated to pay benefits for injury arising out of the use of an uninsured motor vehicle "may recover" reimbursement of such benefits from the owner of the uninsured vehicle).

Nowhere in the no-fault act, however, is a cause of action for recovery of PIP benefits conferred on an injured person's healthcare provider. Only in two sections of the act are healthcare providers singled out: MCL 500.3157, and MCL 500.3158(2). Under §3157, healthcare providers are prohibited from charging more than a reasonable amount for their

services rendered, and in no event more than they would customarily charge in cases not involving insurance. Under §3158(2), healthcare providers are required to produce records and reports, upon request of an insurer handling a PIP claim, regarding the injured person's history, condition, treatment and dates and costs of treatment. Neither of these sections, however, by express terms or by implication, come close to conferring on healthcare providers a cause of action against the no-fault insurer.[10]

Nor, finally, does §3112 of the act confer rights on healthcare providers. As detailed in the preceding section, the opening sentence of §3112 expressly–and purposely–recognizes rights possessed by an "injured person" and, in the case of death, by "dependents" of the injured person. Nothing in the provision suggests that benefits are payable "to or for the benefit of" anyone *other* than these two classes of persons.

In the end, what the healthcare providers assert as the basis of their alleged right of action against no-fault insurers is not so much *the text* of the no-fault act but the spirit or overall design of the no-fault act, and policies that they believe will better advance the general purpose of providing motor vehicle accident victims "with assured, adequate, and prompt reparation for certain economic losses." *Cruz v State Farm Mut Auto Ins Co*, 466 Mich 588, 595; 648 NW2d 592 (2002) (citation omitted). See, Appellee Covenant Medical Center's Brief on Appeal, p. 46; Amicus Curiae Brief of Michigan Health and Hospital Association, pp. 20-

[10] Plaintiff-Appellee, Covenant Medical, cites §3157 as supportive of an implied right of action, as it assures healthcare providers that they "may charge a reasonable amount" for their services rendered (as if they would not be able to do so absent an affirmative statutory mandate). What Plaintiff's brief strains to avoid acknowledging is that this affirmation is provided in the context of a direct *prohibition* against charging *more* than would ordinarily be charged in the cases not involving insurance. See, Appellee Covenant Medical Center's Brief on Appeal, p. 8.

22. It is precisely this same approach that this Court addressed, and rejected, in *Titan Ins Co v Hyten*, 491 Mich 547; 817 NW2d 562 (2012), when it overruled *State Farm Mut Auto Ins Co v Kurylowicz*, 67 Mich App 568; 242 NW2d 530 (1976).

The Court earlier had held that an insurer may in defending a claim avail itself of traditional legal and equitable remedies based on fraud, even if the fraud was easily ascertainable and the claimant was a third party. *Keys v Pace*, 358 Mich 74; 99 NW2d 547 (1959). Years later, when faced with the same issue, the Court of Appeals in *Kurylowicz* rejected *Keys* "'in light of the intervening legislation [the no-fault act] and the public policy of the State of Michigan which such legislation implies...'" *Kurylowicz*, 67 Mich App at 577 (as quoted in *Titan Ins Co v Hyten*, 491 Mich at 563). The court in *Kurylowicz* had based its holding on the no-fault act's "crystal clear" policy that accident victims have access to a source of recovery for the losses. *Titan*, 491 Mich at 564-565, quoting *Kurylowicz*, at 574.

Observing that no statutory text expressly indicated that an insurer may *not* void a policy for fraud, whether easily ascertainable or not, the *Titan* Court held the Court of Appeals to have erred in purporting to glean an overarching "policy" from the act rather than let the actual text of the act–which, after all, emerged from extensive legislative negotiation and compromise–speak for itself. *Titan*, 491 Mich at 565 ("[w]e believe that the policy of the no-fault act is better understood in terms of the actual provisions than in terms of a judicial effort to identify some overarching public policy and effectively subordinate the specific details, procedures, and requirements of the act to that public policy").

This is precisely the same approach ultimately being asserted in this case by Covenant Medical and its amici curiae. No provision in the no-fault act confers on healthcare providers

a right to sue for no-fault benefits, where they qualify as neither an "insured" under the insurance contract, an injured person, nor a surviving dependent of an injured person. Rather, they maintain that they *should* have the right to sue, based on a combination of what they perceive to be the better public policy and a gloss hovering somewhere just above the actual text. To be sure, the Court of Appeals already has proceeded down this path. This Court, much as it did in *Titan* when it overruled *Kurylowicz*, should reject the unfounded notion that providers possess a right of action against no-fault insurers, and leave the healthcare providers' arguments to be addressed, if at all, by the Legislature:

> The no-fault act, as with most legislative enactments of its breadth, was the product of compromise, negotiation, and give-and-take bargaining, and to allow a court of this state to undo those processes by identifying an all-purpose public policy that supposedly summarizes the act and into which every provision must be subsumed, is to allow the court to act beyond its authority by exercising what is tantamount to legislative power.

Titan Ins Co v Hyten, 491 Mich at 565.

One will search the no-fault act in vain looking for any provision that creates a cause of action in favor of a healthcare provider. If providers thus have no statutory cause of action, and they likewise are not "intended third-party beneficiaries" so as to possess a contractual basis to sue the insurer, the very premise of the Court of Appeals' holding in this case collapses like a house of cards. Amicus Curiae IIM submits that, absent an assignment from the injured person, there simply is no right or basis for a healthcare provider "to bring a claim against an insurer for the payment of no-fault benefits." *Covenant Medical*, 313 Mich App at 54. The Supreme Court is urged to so hold.

C. Direct answers to the three questions posed by the Supreme Court's Order of May 27, 2016.

In its order granting State Farm's application for leave to appeal, the Court requested briefing on three specific questions: "(1) whether a healthcare provider has an independent or derivative claim against a no-fault insurer for no-fault benefits; (2) whether a healthcare provider constitutes 'some other person' within the meaning of the second sentence of MCL 500.3112; and (3) the extent to which a hearing is required by MCL 500.3112."[11] Amicus Curiae IIM responds to these questions directly as follows.

1. Does a healthcare provider have either an independent or derivative claim against a no-fault insurer for no-fault benefits?

The answer is that a healthcare provider does *not* have an independent claim against a no-fault insurer for recovery of no-fault benefits; and it would have a derivative claim only were it to *acquire* an injured person's claim by assignment.[12]

As previously detailed, §§ 3114 and 3115 of the act identify who possesses a right to assert a "claim" against a no-fault insurer, and §3112 identifies to whom (and for whom) benefits are payable. A "claim" for benefits is *expressly* conferred only upon the person suffering bodily injury, §§3114 and 3115; but since benefits also are made payable to and for the benefit of a deceased accident victim's surviving dependents, surviving dependents likewise are held to possess a "claim" for benefits–albeit a claim that is "derivative" of the

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[11] *Covenant Medical Center, Inc v State Farm Mut Auto Ins Co*, No. 152758 (Order, May 27, 2016).

[12] Alternatively, a healthcare provider could obtain a judgment against its accident victim patient and thus, by garnishment against the insurer's alleged coverage of the treatment expenses, likewise acquire a derivative claim of the injured person. See, *Ludmer v Erie Ins Exchange*, 441 A2d at 1296 (discussed *supra*).

direct claim held by an injured person. *Belcher v Aetna Cas & Surety Co*, 409 Mich at 254-255.

No provision in the no-fault act, however, confers upon an injured person's provider of services a right to "claim" benefits, either expressly or by implication. Contrary to the premise repeatedly asserted, §3112 does not do so. Under this statutory provision, benefits are payable *only* (1) to an **injured person**, (2) for the benefit of an **injured person**, (3) to a fatally injured person's **surviving dependents**, or (4) for the benefit of a fatally injured person's **surviving dependents**. Since a healthcare provider is *not* an "injured person" and is *not* a "surviving dependent" of an injured person, it follows that no-fault benefits are neither payable *to* a healthcare provider nor *for the benefit of* a healthcare provider.[13]

Precisely the same issue was recently litigated under ERISA, where healthcare providers were held to lack a right of action since they qualify as neither a participant nor a beneficiary of their patient's health plan. In *Brown v BlueCross and BlueShield of Tenn*, 827 F3d 543 (CA 6, 2016), the plaintiff was the owner of a family practice clinic, a healthcare provider that had treated participants and beneficiaries of benefit plans administered by BCBS of Tennessee. To be sure, ERISA is an entirely separate statutory scheme with its own unique provisions; yet *Brown*'s discussion of the provider's rights in that case is extremely illuminating.

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[13] Thus within the terminology of §3112, when a healthcare provider receives a check from a no-fault insurer for treatment rendered to an insured accident victim, the check technically does not represent payment of benefits "*to*" the healthcare provider; rather, it is a payment made "*for the benefit of*" the "*injured person*." This is necessarily so since, under the statute, benefits are not payable "to" a healthcare provider and they are not payable "for the benefit of" a healthcare provider.

Like ERISA, the no-fault act extends enforcement authority not only to policyholders (i.e., parties to the insurance contract) but also to non-contracting "injured person[s]" (intended beneficiaries); and like Covenant Medical Center in the case at bar, the family practice clinic in *Brown* argued that providers possess a right to sue since they were intended "'to receive and [do] in fact receive Plan benefits in exchange for medical care provided to participants.'" 827 F3d at 545. The Sixth Circuit Court of Appeals rejected this theory. "'The fact that [a healthcare provider] may be entitled to payment from [an insurance company] as a result of her clients' participation in an employee benefit plan does not make her a beneficiary for the purpose of ERISA standing.'" *Id*., at 545-546, quoting *Ward v Alternative Health Delivery Sys, Inc*, 261 F3d 624, 627 (CA 6, 2001).

As in the case at bar, the argument in support of a provider's right to claim benefits in *Brown* ultimately centered on the fact that healthcare providers regularly receive payments for their services directly from the insurer, and that such is expected and even intended under the statutory scheme. As "an excellent summary of the logic behind" the *rejection* of this argument, the *Brown* court quoted the following from another circuit's opinion:

> "Beneficiary," as it is used in ERISA, does not without more encompass healthcare providers. Although the term "benefit" is not defined in ERISA, we are persuaded that Congress did not intend to include doctors in the category of "beneficiaries." Benefits to which a beneficiary is entitled are bargained-for goods, such as "medical, surgical or hospital care," rather than a right to payment for medical services rendered. ... While [the Provider] may indeed be entitled to a benefit *qua* benefit through operation of the plan–*i.e.*, payment for its medical services–[the Provider] confuses the issue. **The "benefit" the plan provides belongs to [the Provider's] patients; [the Provider's] claim to payment for covered services is a function of how [the**

> **insurer] reimburses healthcare providers under the Benefits Plan. The right to payment does not a beneficiary make**.

Rojas v Cigna Health and Life Ins Co, 793 F3d 253, 257-258 (CA 2, 2015), as quoted in *Brown*, 827 F3d at 546 (emphasis added).

The court in *Brown* thus followed several other circuits and concluded that healthcare providers do *not* possess a direct right of action against their patients' insurers and benefit plans. It went on to hold, however, that when a patient assigns his or her right to insurance benefits to a healthcare provider, the provider acquires a right to sue for payment of the benefits, although the right obtained is *derivative* of the assignor's rights such that the assignment transfers no more and no fewer rights than the assignor had to convey. *Brown*, 827 F3d at 547-548. This point leads directly to the next question, which is necessarily tied to the first question.

2. Does a healthcare provider constitute "some other person" within the meaning of the second sentence of MCL 500.3112?

Determining whether a healthcare provider constitutes "some other person" as the phrase appears in the second sentence of §3112 requires recognition that "some other person" appears as part of a slightly larger phrase, "... *the claim* of some other person." *Id*. (emphasis added). In this context, it follows that "some other person" must refer to *anyone* who possesses a "claim" against the no-fault insurer. The answer to the question of whether a healthcare provider constitutes "some other person," therefore, is that it could -- *if* the provider is an assignee of a claim assigned to it by an injured person.

Otherwise, for the reasons previously detailed, a healthcare provider possesses no "claim" to assert against the no-fault insurer. To be sure, §3112 not only permits but

manifestly envisions that payments will be issued to *non-claimants*, including in particular healthcare providers, *for the benefit of* injured persons and, in the case of death, their dependent survivors–i.e., those who *do* qualify as claimants under the act. For instance, in addition to healthcare providers, benefit payments may be issued directly to a dependent minor's caregiver, or to an injured person's provider of household replacement services, or a home-modification contractor. In none of these instances would such payment recipients qualify as "some other person" within the meaning of §3112, however, because none have either a statutory or contractual basis for asserting a "claim" against the insurer. A healthcare provider is in no different a position than any of these other payment recipients.

3. To what extent is a hearing required by MCL 500.3112?

Under §3112, the insurer, the claimant or any other interested person may apply to the circuit court for an order designating payees or apportioning the amounts to be paid among payees "[i]f there is doubt about *the proper person to receive the benefits* or the proper apportionment among the persons entitled thereto[.]" *Id*. (emphasis added). Such uncertainty among persons potentially entitled "to receive the benefits" can only occur where there is more than one person entitled to claim benefits–which only occurs in the case of death, where the type of benefits at issue are survivors loss benefits. But where the injured person remains alive, there are no "dependent survivors" to assert a claim and, accordingly, there will only be *one* person potentially entitled to claim benefits.

Thus a fundamental error in the Court of Appeals' opinion in this case is its conclusion that a healthcare provider's submission of bills to a no-fault insurer constitutes a valid and enforceable "claim" capable of creating "doubt about the proper person to receive the

benefits," thereby rendering the insurer's payment of benefits made in "bad faith" even though made directly to the injured person who, indisputably, was entitled to the benefits. *Covenant Medical*, 313 Mich App at 53. The only conceivable way a healthcare provider could submit a "claim" and create "doubt" requiring a circuit court hearing under §3112 would be if the claim included written proof that the injured person had assigned his right to the provider to collect benefits for the charges incurred for his care and treatment. And even then, a hearing would only be warranted to resolve "doubt about the proper person to receive the benefits" if the injured person denied the validity of the claimed assignment.

Apart from any such potential issues over an assignment of benefits, however, "doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto" can only arise when there is uncertainty *as to who qualifies as a "dependent"* under MCL 500.3110 *or how much each dependent is entitled to receive*. Only in such instances would a §3112 hearing be warranted. Reading the balance of §3112 in conjunction with §3110 makes this clear.

Under §3110(1), "doubt" can emerge as to whether a surviving spouse or minor child is a "proper person" to receive benefits if it is unclear whether they were living in the same home as the accident victim. "Doubt" also can emerge under §3110(2) over the "proper apportionment" of benefits since "the extent of [one's] dependency shall be determined in accordance with the facts." Similarly, "doubt" can emerge under §3110(3) since this subsection conditions "dependent" status on particular factual inquires. In these circumstances, a hearing may be necessary for the circuit court to "designate the payees and make equitable apportionment" of benefits. Notably, both of the provision's exceptions that allow for

payments to be made without a hearing, §3112(a) and §3112(b), are concerned exclusively with dependents' benefits.

Apportionment hearings under §3112 thus should generally be required only in claims for survivors loss benefits, since only in this context (with the exception of a disputed assignment of a claim) can there be more than a single person capable of asserting a "claim" for benefits. The Court should so hold, consistent with the overall position advanced herein that healthcare providers simply do not possess a right to claim benefits from a no-fault insurer.

II. IN THE EVENT HEALTHCARE PROVIDERS ARE DETERMINED TO POSSESS A RIGHT TO CLAIM PAYMENT OF NO-FAULT BENEFITS OWED BY AN INSURER, ANY SUCH CLAIM WOULD REMAIN DEPENDENT ON THE INSURER BEING OBLIGATED TO PAY BENEFITS ON BEHALF OF THE INSURED, AND THUS WOULD BE BARRED BY A RELEASE OF CLAIMS OR OTHER RESOLUTION OF THE INSURED'S RIGHTS AGAINST THE INSURER.

In granting summary disposition for Defendant State Farm in this case, the circuit court declined to resolve the threshold question of whether healthcare providers could ever have a viable claim against an insurer independent of the injured person's claims. Instead, it determined that the Release executed by the injured person was dispositive:

> Notwithstanding any argument as to a medical provider's ability to pursue a direct action on a claim for the payment of no-fault benefits owed by an insurer, such an action remains dependent on the insurer being obligated to pay benefits to the provider on behalf of the insured.

(Opinion and Order of the Court, 5/15/2014, p. 4) (Joint Appendix, 76a).

The circuit court held that State Farm was free of any potential liability based on the insured's release of all claims, finding support in *Moody v Home Owners Ins Co*, 304 Mich

App at 440 (Joint Appendix, 78a -- "'the providers' claims against [the insurer] are completely derivative of and dependent on Moody's having a valid claim of no-fault benefits against [the insurer]'") (quoting *Moody*, *supra*). It determined "that an injured party may waive claims for no-fault benefits owed on his behalf under the party's contract of insurance and that the provider is bound by that release." *Id*.

The court also examined MCL 500.3112 to determine whether the "[p]ayment by [the] insurer ... discharge[d] the insurer's liability," but concluded that the statutory issue was moot in light of the release of claims: "As the settlement and release discharges State Farm from liability in this matter, it is unnecessary to consider whether or not State Farm would ***also*** be discharged from liability by operation of §3112 even if there was no settlement and release." (Joint Appendix, 79a) (emphasis added).

The following will show, in the event providers are found to have a right to sue no-fault insurers directly, that the circuit court's analysis was correct, while the Court of Appeals' rejection of the analysis is defective on its face.

By its terms, §3112 extends a protection to the insurer–an assurance–allowing the insurer to issue a payment of benefits and know, subject to the stated limitation, that it has discharged its liability with respect to those benefits:

> ***Payment*** by an insurer in good faith *of personal protection insurance benefits*, to or for the benefit of a person who it believes is entitled to the benefits, *discharges the insurer's liability to the extent of the payments* unless the insurer has been notified in writing of the claim of some other person.

MCL 500.3112 (emphasis added). The statute speaks only of liability being discharged by mere payment. "Payment," notably, is itself recognized as a defense to claims–indeed, it is

among the affirmative defenses included in MCR 2.111(F)(3)(a), as are the *separate* affirmative defenses of "release" and "satisfaction."

Under §3112, when an insurer issues a payment of PIP benefits in good faith to the injured person or for the benefit of the injured person, it can validly maintain that it has discharged its liability; but this assurance is limited by the caveat stated in the provision's "unless" clause. By its terms, the clause takes back §3112's assurance of discharge if the insurer has written notice of someone else's claim for those benefits. The "unless" clause, in other words, is nothing more than an exception to the stated rule that an insurer's "payment," by itself, discharges the insurer's liability as a matter of law.

Manifestly, a different issue is presented if the insurer has more to rely upon than its mere "payment" of benefits. For instance, suppose that a trial between the insurer and the injured person results in a verdict against the insurer, after which payment is made solely to the injured person pursuant to the judgment. For that matter, suppose, alternatively, that the parties resolved their dispute amicably with a consent judgment–whether under the case evaluation procedures of MCR 2.403(M)(1) or otherwise–after which the insurer issues payment solely to the injured person pursuant to the consent judgment. Under either circumstance, the insurer would be assured that its liability was discharged based not on §3112 and the mere fact of its "payment" but on its Satisfaction of Judgment (see, MCR 2.620). If anyone in privity with the injured person thereafter attempted to assert an already existing claim, based on the insured's PIP coverage for the same accident, the insurer would have no need to rely on §3112 since the claim would be barred by *res judicata* (i.e., the affirmative defense of "satisfaction").

Indeed, since a voluntary dismissal with prejudice acts as an adjudication on the merits for *res judicata* purposes,[14] the same point applies where an insurer agrees to settle a litigated claim with the injured person and the case is dismissed with prejudice. Accordingly, if, *as in the case at bar*,[15] a no-fault insurer pays its insured PIP benefit monies in settlement of a disputed claim in exchange for a dismissal of the action and a comprehensive Release of all claims, it would have no need to rely on §3112's "discharge of liability" in the event someone thereafter were to assert a derivative claim against the insurer. As the circuit court held, the release covering existing and future claims for benefits remains enforceable against one who would rely on the injured person's entitlement to benefits, such as a medical provider (Joint Appendix, 78a). The insurer's liability in such instance is discharged both by "release" and *res judicata*.

In short, when an injured person's claim is resolved by a judgment (consent or otherwise), an order of dismissal with prejudice, or a release of claims, the insurer's mere "payment of benefits" is not, and need not be, the basis on which the insurer's liability is deemed discharged. The "unless" clause of §3112 on which the Court of Appeals relied simply has no application since its function is solely to limit the breadth of a discharge by "payment."

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[14] *Limbach v Oakland County Rd Comm*, 226 Mich App 389, 395-396; 573 NW2d 336 (1997).

[15] The record shows that State Farm's payment of benefits in exchange for a release of claims from its insured, Jack Stockford, occurred in a litigated action, *Stockford v State Farm Mut Auto Ins Co*, Tenth Circuit Docket No. 12-016370-CK, which presumably was "resolve[d]" by entry of a dismissal with prejudice. See Opinion and Order of the Court, p. 1 (Joint Appendix, 73a).

The Court of Appeals' analysis in this regard is patently flawed. Citing §3112 (indeed, purporting to rely on its "plain text"), the opinion states that when an insurer has written notice of a third party's claim, the insurer cannot discharge its liability "by settling with its insured." *Covenant Medical*, 313 Mich App at 53. The statute, however, does not say this. It provides only that liability is not discharged *simply by making a payment*. It does not purport to address settlement of claims.

The Court of Appeals' opinion proceeds to announce, even more explicitly, that where there is written notice of a provider claim, §3112 dictates that a "payment *and release* does not extinguish the provider's rights" (313 Mich App at 54) (emphasis added); that, unless the insurer complies with §3112, "an insured's *agreement to release the insurer* in exchange for a settlement, does not release the insurer as to the provider's noticed claims" (*id.*) (emphasis added). Again, the opinion's statements are utterly unsupported by the text of the statute. While the "unless" clause of §3112 operates to erase an insurer's "discharge[]" of liability otherwise gained by its mere payment of benefits, that is as far as it goes. It does not purport to invalidate a release that would discharge the insurer from all liability arising out of the insured person's injury.

The holding of the Court of Appeals thus effectively transforms the "unless" clause of §3112 from a limitation on the scope of the preceding "payment" provision to an affirmative grant of immunity on the part of healthcare providers from the defenses of "release" and *res judicata*. Under the court's opinion, the hearing procedures identified in §3112 not only apply when an insurer attempts to meet its obligations by issuing a payment of benefits but are imposed on any transaction that *includes* payment of monies by the insurer, including

negotiated settlements in exchange for a release of claims and payments made in satisfaction of a judgment.

The Court should conclude that §3112, by its very terms, only defines the extent to which a simple "payment" of PIP benefits operates to discharge the insurer's liability; the Court should conclude that §3112 provides the no-fault insurer with assurance that it can issue payment to or for the benefit of the injured person and, subject to the stated exception, know that it has discharged its liability to the extent of the payment. By extending to insurers this assurance of a "safe method" for paying benefits, the statute advances the act's purpose of promoting prompt payment of benefits. *Miller v Auto-Owners Ins Co*, 410 Mich 538, 568; 302 NW2d 537 (1981), citing *Shavers v Attorney General*, 402 Mich at 578-579. It does not, however, eliminate the effect of a valid release agreement or the conclusive effect of a judgment or an order of dismissal with prejudice.

Accordingly, in the event healthcare providers ultimately are held to possess any right to sue no-fault insurers directly, the Court should conclude that the circuit court in this case applied §3112 correctly. Once the injured person resolved its dispute with the insurer and executed a valid release of all claims, no insurance benefits remained payable to or for the benefit of the injured person. The release ended the insurer's obligation to pay benefits under its contract of insurance. (Opinion and Order of the Court, p. 4, Joint Appendix, 76a).

CONCLUSION

For the reasons detailed above, Amicus Curiae IIM submits that the Court of Appeals' opinion in this matter must be reversed, specifically on the basis that providers fundamentally lack a "claim" to recover benefits from a no-fault insurer. The notion that an injured person's

healthcare provider has an independent right to bring an action against an insurer for the payment of no-fault benefits, 313 Mich App at 54 (Joint Appendix, 82a), on which premise the viability of the Court of Appeals' decision depends, is unfounded and insupportable.

In the event the Court nevertheless were to accept that healthcare providers have a right to sue for payment of an insured's no-fault benefits, however, the right would be derivative of and dependent upon whatever right the injured person has with respect to recovery of his or her benefits. A release of such right by the injured person necessarily would preclude any recovery by the injured person's providers. In no event can the Court of Appeals' holding survive from an analytical standpoint; nor should it survive, given the adverse impact the newly imposed procedures have on parties' ability to resolve no-fault claims efficiently and with a minimum of judicial intervention.

Amicus Curiae, INSURANCE INSTITUTE OF MICHIGAN, therefore, respectfully urges the Court to hold that the no-fault act confers no right of any kind on a healthcare provider. Alternatively, at a minimum, the Court should hold that a settlement by the injured person with his no-fault insurer binds any healthcare provider who has provided him treatment.

Respectfully submitted,

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STATE OF MICHIGAN

IN THE SUPREME COURT

COVENANT MEDICAL CENTER,

Plaintiff-Appellee,

v.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, a Michigan insurance corporation,

Defendant-Appellant.
_____/

Supreme Court No. 152758

Court of Appeals No. 322108

Saginaw County Circuit Court No. 13-020416-NF

PROOF OF SERVICE

DANIEL S. SAYLOR certifies that he is associated with the law firm of GARAN LUCOW MILLER, P.C., attorneys for Amicus Curiae, INSURANCE INSTITUTE OF MICHIGAN, and that on October 20, 2016, he served the **Amicus Curiae Brief of the Insurance Institute of Michigan**, and this **Proof of Service**, upon counsel for Plaintiff-Appellee, Richard E. Hillary, II, Esq., and Christopher J. Schneider, Esq., **Miller Johnson**, 250 Monroe Ave. N.W., Ste. 800, Grand Rapids, MI 49503, respectively, to hillaryr@millerjohnson.com, and schneiderc@millerjohnson.com; upon counsel for Defendant-Appellant, Jill M. Wheaton, Esq., and Courtney F. Kissel, Esq., **Dykema Gossett, P.L.L.C.**, 2723 S. State Street, Ste. 400, Ann Arbor, MI 48104, respectively, at jwheaton@dykema.com, and ckissel@dykema.com; and upon all counsel for the amici curiae participating in this matter, by directing the Court's *TrueFiling* system to deliver true copies via e-service to all.

/s/ Daniel S. Saylor
DANIEL S. SAYLOR